



Part II – Risk Management

What is Risk Management?

Risk Management is the development of practice strategies to prevent patient harm and practitioner liability. This is achieved through the development of clearly defined practice guidelines intended to reduce and prevent malpractice actions. Properly implemented risk strategies will decrease the potential for malpractice claims and increase the quality of care for patients.

What is Malpractice?

Malpractice is a dereliction from professional duty or a failure to exercise an accepted degree of professional skill or learning by a physician rendering professional services which results in injury, loss or damage. Malpractice is further defined as an injurious, negligent or improper practice.ⁱ

The Doctor of Chiropractic practices in a highly litigious society where legal expenses, settlements and jury awards total in excess of 100 billion dollars per year. While there is a low incidence of legal cases proceeding to jury trial, medical malpractice cases go to trial more frequently than other types of personal injury litigation. This increased incidence of litigation is due to societal fascination with the concept of litigation, sensationalized accounts of enormous jury awards, impersonal health care perceptions and higher expectations of doctors and treatment procedures due to technological advancements.

How is Malpractice Proven?

There are four primary components necessary to successfully prosecute a malpractice claim: Duty, Dereliction of Duty, Direct Causation, and Damage.

Duty

Duty is something that one is expected or required to do by moral or legal obligation. Duty is further defined as an action or task required by one's position or occupation.ⁱⁱ The primary element of a successful malpractice action is proving that the physician owed some duty to the claimant. It must be determined that a doctor--patient relationship had been established. This relationship does not require a written contract. For example, rulings have been made which establish a doctor--patient relationship when a doctor gives professional advice during a social encounter. To avoid the establishment of a doctor--patient relationship, avoid giving professional advice during social encounters, train staff not to



give professional advice and avoid giving telephone advice. Also, an independent chiropractic examiner should never provide treatment services, or offer a diagnosis, prognosis or future treatment plan to an examinee. Doing so creates a doctor - patient relationship which can result in a malpractice claim. Strict adherence to independent chiropractic examination guidelines and procedures reduces the likelihood of successful malpractice prosecution.

Duties of a Doctor of Chiropractic

The doctor must abide by the rules and regulations promulgated by their State Board of Chiropractic Examiners.

The doctor must provide only those chiropractic treatment services which fall within their states scope of practice.

The doctor must stay abreast of treatment and technological advancements and meet the requirements for their states continuing education credit hours of postgraduate instruction.

The doctor must explain to the patient their treatment plan and the risks of treatment. Also, treatment options should be discussed.

The doctor must receive consent by the patient for treatment.

The doctor must perform a thorough history taking of a patient's subjective complaints.

The doctor must perform a thorough chiropractic, orthopedic and neurological examination of the patient.

The doctor must render an accurate diagnosis.

The doctor must perform appropriate diagnostic testing procedures consistent with the etiology and timing of the patient's injury / condition, patient subjective complaints and the provider of care's objective findings. If radiographic studies are utilized, they must be taken of the area/areas of patient complaint.

The doctor must offer an efficacious course of care with the goal of amelioration of symptomatology or reduction of subluxation, depending upon philosophy.

The doctor must offer quality treatment within a duration of time and at a frequency consistent with general chiropractic and cross discipline treatment parameters and guidelines. A general rule of thumb is the frequency of treatment should decrease over time commensurate with patient progress.

Any adjunctive physiotherapy modalities utilized should be consistent with the diagnosed condition with consideration of the modalities' physiological effects.



The doctor must document daily patient encounters utilizing the S.O.A.P. note format.

Where significant clinical progression is not noted, the prudent DC should refer the patient to the appropriate practitioner for alternative care. Failure to refer may result in the DC being held to the same standard of care as the provider to whom the referral should have been made.

The doctor must document clinical progression to warrant future care consideration.

The doctor must ensure patient confidentiality.

The doctor must never abandon a patient.

The doctor must only bill for those services rendered.

Duties of the Doctor of Chiropractic Imposed by Law

Continuing education credit requirements and license renewal.

State chiropractic laws.

Most states have legislative mandates requiring the DC to report cases of child abuse.

Alterations of Duties:

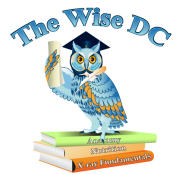
Duties can be altered by one's state chiropractic association. However, typically, a position espoused by a professional association does not have the force of law.

Duties can be altered by one's state licensing board, which have the full force of law.

Duties can be altered by court rulings.

Dereliction of Duty - any actions or tasks that do not meet the requirements of one's position or profession involving a deviation from standards of care.

Direct Causation - it must be proven that a negligent act occurred which directly caused the patient injury.



Negligence--failure to exercise the care that a prudent person usually exercises. ⁱⁱⁱ In a malpractice action it must be proven that the doctor failed to perform his duty with reasonable skill and or performed a procedure that was outside of his scope of practice, expertise and training.

In order to successfully prove malpractice, the plaintiff's attorney must prove causation to a reasonable degree of medical probability. This implies that it is more probable than not, (i.e., there is more than 50% probability) that a certain condition was caused by a negligent action by the accused doctor.

Cause: An agent, circumstance or event which is capable of producing a new effect or aggravating an ongoing or preexisting effect.

Effect: A diagnosis, status, function, condition or impairment which can result from or be aggravated by a cause.

Causation exists when: A given cause (A) and a given effect (B) are associated within a reasonable degree of medical probability. When this is true, all three of the following points are assumed to be correct and medically probable:

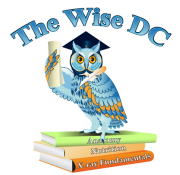
The cause (A) is medically probable - (A) is more likely than not the cause and / or aggravator of the problem.

The effect (B) is medically probable – (B) is more likely than not the correct diagnosis or condition.

Cause and effect are not related in a medically probable manner if: Either (A) or (B) or both is considered to be possible, but not probable, the causal association cannot be upheld as being medically probable. Further, no number of possible causes can be taken together and viewed as a probable cause. Clearly, the same notion applies to possible effects.

First, an event took place and is verified. Second, the patient is examined and is found to have an injury. Third, the event could cause the injury, and if so: Fourth, it is medically probable the event caused the injury.

Medically probable: A notion that it is more probable than not that something is true, from a medical standpoint, in other words, a greater than 50% probable.



Medically possible: A notion that it is more likely than not that something is true from a medical standpoint. In other words, the particular effect could be due to a particular cause, but it is not more than 50% likely.

Aggravation: A stimulus capable of worsening. The "status quo" of a susceptible entity or condition. The concept of aggravation must be considered as either temporary (self-limited aggravation) or permanent (substantive aggravation). The AMA Guides defines an aggravation as "a physical, chemical or biological factor which may or may not be work related, contributing to the worsening of a preexisting medical condition or infirmity in such a way that the degree of permanent impairment is increased by more than 3%," (AMA Guides, 4th edition glossary P.315).

Exacerbation: Temporary increase in symptoms without persistent effect or event.

Preexisting condition: Antedating event.

A conclusion that a **cause** did contribute to an **effect** or impairment must rely on the documentation of **circumstances** that were present and verification that the **type** and **magnitude** of the factors were sufficient and bore the necessary **temporal** relationship to the condition. Note, there is a relationship between all five factors- Cause, Effect, Type, Magnitude and Temporal Relationship. One must be sure in the cause and effect relationship before definitively stating a causal relationship.

In determining causation and aggravation, the following is often reviewed:

Medical records attributable to a cause.

Medical records attributable to the effect.

Past medical records.

Results of tests or diagnostic procedures.

Damage - a loss sustained by a party for which recovery is sought in a malpractice lawsuit.

If any of the four elements necessary to prove malpractice are absent (Duty, Dereliction of Duty, Direct Causation or Damage) then the accused doctor's chances of winning the lawsuit are greatly increased.



In short, a doctor can lose a malpractice claim if the plaintiff's attorney can prove the doctor had a duty, was derelict in his duty, and his actions or inactions directly caused damage to the claimant.

ERRORS

An error is an act or condition of ignorance or imprudent deviation from a code of behavior. Errors fall into two categories;

Errors of Omission--an example would be the failure to diagnose. Diagnosis is the art or act of identifying a disease from its signs and symptoms and distinguishing one disease from another.

Errors of Commission--the performance of an act which results in injury. An example of an error of commission would be fracturing a rib while adjusting a thoracic vertebra.

Analysis of Errors of Omission

A failure to perform any physical examination or the appropriate examination given the history and patient complaints. For example, due to philosophy, some DC's will perform chiropractic analysis (palpation and leg length checks etc), but do not perform review of systems, and orthopedic or neurological evaluation. A protective, risk management strategy is to perform chiropractic analysis, and orthopedic and neurologic examination testing procedures.

A failure to correlate examination findings and render an accurate diagnosis. Failure to diagnose cancer is a primary risk management concern.

Failure to appropriately refer a patient.

Examples of Errors of Commission



Chiropractic Manipulation Resulting in Disc Herniation

Approximately 20% of all chiropractic malpractice claims involve allegations that a chiropractic manipulation resulted in a disc herniation. In a large percentage of these claims, side posture adjusting techniques were identified as the maneuver which caused the disc herniation.

Chiropractic Manipulation Resulting In Fractures

Fractures are a medically possible result of chiropractic manipulation. The most common type of fracture resulting from a chiropractic manipulation is a rib fracture in an osteoporotic female patient.

Chiropractic Manipulation and Cerebrovascular Accidents

Cerebrovascular accidents (CVA) also known as Vertebrobasilar Stroke (VBS) caused by a cervical manipulation result in a disruption of blood flow through the vertebral arteries, which ascend through the transverse foramen in the cervical spine and join together forming the basilar artery. The basilar artery provides vascular input to the posterior portion of the circle of Willis and then to the posterior cerebellar artery. The change in vascular flow through the vertebral artery causes ischemia to the cerebellum or the brainstem, especially the medulla. Ischemia to this area produces the lateral medullary or Wallenberg syndrome, which consists of; an ipsilateral loss of the following cranial nerves (V Trigeminal nerve (sensory - touch, pain and temperature to the face; motor - muscles of mastication); IX Glossopharyngeal nerve (sensory - posterior 1/3 of the tongue; motor - stylopharyngeal muscle); X Vagus nerve (gag reflex) and XI Spinal Accessory nerve (motor - trapezius muscle, and sternocleidomastoid muscle)); cerebellar ataxia (irregular or loss of motor coordination); and contralateral loss of pain and temperature sensation. Damage to the patient due to CVA (stroke) may include hemiparesis, hemiplegia or even death. CVA after manipulation represents 4% of all malpractice suits filed each year.^{iv}

Manipulation - Induced Vertebral Artery Syndrome: Identification of Potential Patient at Risk.

Incidence - Over 50 documented cases since 1947; over 12 deaths; mean age, 37.9; female patients nearly 2:1.^v

Authoritative sources opine that the probability of stroke resulting from a cervical manipulation is one in one million. However, malpractice claims alleging stroke have increased dramatically.^{vi} It is prudent to perform stroke screening tests such as George's Test.

George's Test also known as the Cerebrovascular Craniocervical Functional Test

The test should be performed on everyone over 18 years old.



The test has four parts;

Part I - History

Questions are asked regarding the cardiovascular system and related symptomatology ex. Do you have a history of stroke, hypertension etc.? Affirmative answers are presumptive evidence of a high risk patient.

Part II - Integrity of subclavian arteries

Check blood pressure and compare systolic pressures in both arms. A lower systolic pressure of 10 mm Hg. suggests a possible occlusion of an artery on the low side.

Auscultate the subclavian arteries at the subclavian fossa for bruits. (Bruit is a sound caused by turbulent blood flow due to an occlusion).

Part III - Integrity of the carotid arteries

Palpate the carotid arteries found at the level of the thyroid cartilage, anterior to the S.C.M. muscle. The carotid sinus is found at the level of C4.

Auscultate the carotid arteries for bruits.

If there is a possible Subclavian (+ Step II, or carotid artery (+ Step III) occlusion, do not perform Step IV.

Part IV - Vertebrobasilar Artery Functional Maneuver

This test is designed to compress the vertebral arteries. Positive indicators of occlusion would be signs of cerebral ischemia such as nausea, fainting, vertigo and nystagmus. The patient is instructed to hyperextend and rotate their head to the left for 3-5 seconds (watch for indicators) and then to the right for 3-5 seconds (once again looking for indicators of occlusion).

If Steps II, III, or IV is positive, do not perform rotary (rotation & extension) cervical manipulations and refer to a cardiovascular specialist or neurologist.



Injury Caused by Therapies

Injuries can be caused by the improper utilization of adjunctive physiotherapy methods and exercise techniques. To protect against this, know the physiological effects, indications and contraindications for all modalities used and the risks of exercise. Instruct the patient on proper lifting techniques.

Sexual Molestation

To avoid allegations of sexual molestation have a witness (staff member of the same sex as the patient) with you during examinations and treatment.

Practice Limitations

A chiropractor is limited to the utilization of diagnostic and therapeutic procedures which fall within their states scope of practice rules and regulations. It is imperative that every chiropractor know the scope of practice for their particular state. Chiropractors should limit the procedures that they employ to those in which they have had documented training approved by an accredited chiropractic college and or their states Board of Chiropractic Examiners.

Chiropractic Standards of Care

Chiropractic standards of care are not established by chiropractic colleges, state organizations or insurance companies. Conversely, chiropractic standards of care are ultimately decided by a court of law. With the growing number of standard of care cases, a number of states such as California have formulated statutory definitions of failure to conform to standards of care. California defines professional negligence as "A negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed." ^{vii}

Common Causes of Malpractice Lawsuits and Risk Management Strategies

Deviating from the standard of care by performing services outside of the scope of practice promulgated by a state regulatory body may lead to a malpractice claim. Avoid this scenario by knowing and practicing within your states scope of practice.

Failure to inform the patient of adverse consequences of treatment. This omission can be remedied by devising a standard practice protocol at the time of patient induction into your office. For example, create a form which chronicles your discussion with the patient regarding their condition, proposed



treatment, proposed frequency and duration of treatment, risks of the treatment to be utilized, alternative treatment options, and chances of success or failure.

Failure to diagnose, which leads to loss by the patient. This omission can be remedied by increasing your knowledge base in the area of differential diagnosis and following an orderly and strategic clinical reasoning method. Patients seek the services of a physician for two fundamental reasons; 1) to establish the correct diagnosis and 2) to obtain the appropriate treatment. Treatment provided for an incorrect diagnosis fails the patient to the same degree as does diagnosis without appropriate treatment. The diagnosis is obtained only after considering a number of competitive etiologies and progressively eliminating them. This is the process of differential diagnosis. The patients history coupled with their physical examination findings are the most essential components of the differential diagnosis. Approximately 90 percent of the diagnosis is derived directly from the history. While the history plays a significant role in the formulation of a diagnosis, the importance of accurate physical examination findings cannot be overstated. Physical examination findings are valuable in that they demonstrate high sensitivity or specificity for a given pathology.

Deviation from the standard of care through treatment errors such as rib fractures, therapy burns, patient falls from the treatment table and other assorted on table injuries (pinch injuries and finger amputations caused by mechanized tables) is a common cause of malpractice lawsuits. To avoid these errors of commission, perform adjustive techniques which were taught to you at your accredited chiropractic college, train your staff to administer adjunctive physiotherapy modalities, and make sure to guide patients on and off of your treatment table.

Failure to provide adequate exercise and home therapy instruction may result in a malpractice claim. Consequently, it is advisable for the provider of care to demonstrate proper exercise techniques and instruction on self administered home therapy.

Failure to refer the patient for necessary ancillary diagnostic testing or cross discipline examination is common causes for malpractice lawsuits. In a case where significant clinical progression is not noted, the prudent physician should either alter his treatment, or refer the patient for additional testing or examination by another physician. When there is a differential diagnosis containing morbid or potentially fatal conditions, the physician is compelled to pursue a testing strategy to rule out or confirm their presence. The testing procedure that is chosen should have a high specificity and sensitivity to the suspected condition. Appropriate test selection is necessary for diagnostic orientation, patient safety and cost effectiveness.

Patient Abandonment-- abandonment occurs when a doctor, without notice, unilaterally discontinues his professional relationship with a patient who is in need of ongoing health care services. A prudent risk management strategy to avoid a claim of abandonment would be for the doctor to personally inform the patient that he can no longer offer professional services to them and allow them sufficient time to find another provider of care. This conversation should be reinforced by a letter sent certified return receipt requested. In the case of a vacationing doctor, coverage arrangements must be made. Retirement or



relocation also requires advanced notice and a reasonable opportunity to secure the services of another provider of care.

Advertisement claims which guarantee a cure are problematic and must be avoided.

The physician who exceeds the consent given to him by the patient may be subject to allegations of battery which can result in civil or criminal actions.

Revealing confidential patient information may result in a lawsuit. It is imperative that the physician personally maintain patient confidentiality and instruct his staff on the importance of patient privacy. Also, the physicians' office should be constructed in such a way to insure privacy. For example, a glass partition between the receptionist and the patient waiting room will assure privacy when discussing collection matters, compliance with treatment and the patient's clinical status.

Sexual Misconduct--Doctors must avoid all situations which give the impression of sexual impropriety. To avoid a claim of sexual misconduct, have a staff member in attendance during the entire patient encounter and only care for a minor in the presence of their parent. When possible, the witness should be of the same gender as the patient.

Office literature can contribute to malpractice claims. Review all office literature carefully. Any literature which makes claims of chiropractic curing specific conditions should be discarded.

Collecting fees can initiate a malpractice action. It is the duty of the doctor to assure all new patients understand the fee arrangements before the patient incurs any charges for services. It is advisable for the physician to separate himself from the actual collection of fees. Disputes arise out of the collection of fees when patients are not satisfied with their care and are being pressured to pay their bill.

The physician should follow up with all patient management discussed with the patient. Failure to maintain proper follow up procedures may result in a malpractice claim.

Lack of physician availability can result in a malpractice action. If an office advertises hours of availability, make sure either the physician or a substitute is available during the stated times.

Chiropractic Malpractice Statistics

According to Princeton Insurance Company, approximately 5 percent of practicing chiropractors are involved in litigation as defendants at any one time. The cost of malpractice insurance is approximately \$1500.00 for limits of liability of \$1,000,000 for each medical incident and \$3,000,000 per annual aggregate.

The average medical specialist pays a six figure annual premium.

Understanding Your Malpractice Insurance Policy



Malpractice premiums are based upon actuarial calculations of risk and claims made for a particular year. The more claims made against a particular specialty, the higher the premium. The relative low cost of chiropractic malpractice premiums is a tribute to the safety of chiropractic treatment methodologies.

Most malpractice insurance policies state that in exchange for a premium payment, the malpractice insurance carrier will defend any claims made against the insured doctor, provide legal services if necessary and pay up to the amount of the policies limits in the case of a doctors errors or omissions stipulated by the policy. Policies typically have limits of liability for each occurrence and per annual aggregate. Therefore, a policy which lists limits of \$1,000,000 / \$3,000,000 will pay up to \$1,000,000 for a single medical occurrence and a total of \$3,000,000 for all claims occurring in a single year. The doctor is personally responsible for all claims which exceed either the occurrence or aggregate limits of their insurance policy.

The doctor should review his policy yearly, and be cognizant of and avoid those actions prohibited by his policy. For example, those doctor's performing insurance consulting activities, such as peer review and independent chiropractic examination, should ascertain if these activities are covered by their policy. Also, it is imperative to report claims of malpractice in an expeditious manner and aid the insurance company in defense of a claim. The doctor should make sure that the declaration portion of their policy lists all employees that provide any type of treatment services as named insured's.

By having a chiropractic associate sign a contract as an independent contractor does not shield the "employer" doctor from malpractice liability. The "employer" doctor is ultimately responsible for the action of the associate. This legal concept is known as *Vicarious Liability*.

Two Types of Malpractice Insurance Coverage

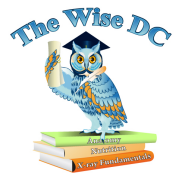
Claims - Made Coverage - Provides coverage for claims made and reported during the policy period even if the claims were due to errors or omissions occurring before that period.

Example:

Scenario 1, Dr. I.M. Target has claims-made coverage for the year 2000. If a claim is made against Dr. I.M. Target in 2000, then he is covered by his policy.

Scenario 2 - Dr. I.M. Target retires in 2001 and discontinues his malpractice insurance coverage. A claim is then filed in 2001 against Dr. I.M. Target for an action that occurred in 2000. Dr. I.M. Target would not have coverage for this incident. A claim filed in 2001; even for an act occurring in 2000 (when Dr. I.M. Target had coverage) is not covered by a Claims-Made policy. This doctor would have been wise to purchase "tail coverage" for an indefinite period. *Claims-Made* coverage is less expensive than *Occurrence* coverage.

Occurrence Coverage - Provides coverage for claims made because of errors or omissions occurring during the effective period of coverage. Example - Dr. Smith purchases Occurrence coverage effective



in 1995. Any negligent action claim which occurred in 1995 would be covered, even if the claim was made in 1995, 1996 or thereafter. Conversely, there would not be coverage for an act that occurred prior to the inception of the policy in 1995, even if the claim was made in 1995.

Doctors switching from Claims-Made coverage to Occurrence coverage should purchase "Gap" coverage. Purchasing appropriate malpractice insurance is an essential risk management strategy.

Patient Consent for Treatment

Consent is compliance in or approval of what is done or proposed by another.^{viii} Consent falls into two categories; Informed Consent and Implied Consent.

Informed Consent

Informed consent involves a verbal interaction between the doctor and patient. Essential elements of informed consent include discussion of the patient's condition, identification and explanation of proposed treatment, warning of the risks or consequences of treatment, disclosure of alternative treatment options and their risks and the probability of success or failure of the proposed treatment. Informed consent should be discussed with the patient before care begins. Having the patient sign a written consent form is a prudent risk management strategy.

"Where there is risk of significant harm from the treatment proposed, this risk must be disclosed, understood, and accepted by the patient. Such informed consent is required for ethical and legal reasons. The best record of consent is one that is objectively documented, such as, a witness's written consent or videotape."^{ix}

The 1984 case of *Mason v. Forgie* involved the concept of informed consent. The court of New Brunswick awarded Hayden Mason a judgment against Dr. Forgie, DC for more than \$200,000 for failing to obtain Hayden Mason's informed consent and failing to advise the patient before initiating treatment of the risks of treatment, particularly the risk of stroke. Hayden Mason was provided a cervical manipulation and suffered a stroke before leaving the doctors office. While the court found that Dr. Forgie was not negligent in using excessive force or with respect to his examination of the patient, he was found negligent in not advising the patient of the risk of stroke.^x

Advise the patient of the risks of treatment and the risks of leaving their condition untreated. Be familiar with statistics regarding unfavorable treatment results. For example, in the *Mason v. Forgie* case, Scott Haldeman, M.D., D.C. opined that the odds of a patient suffering a stroke due to a cervical manipulation are one stroke per one million manipulations.^{xi} Document your discussion of the risks of treatment with the patient and their decision to receive or not receive treatment. If the patient refuses to follow the doctor's treatment recommendations have them sign a notation acknowledging their refusal.

Implied Consent



This form of consent is granted by the patient's voluntary presentation for treatment. Implied consent occurs on each visit to the doctor's office. In general, implied consent takes place after informed consent with the patient having full knowledge of the proposed care plan and the treatment methods to be employed.

The prudent physician should never breach the doctor--patient relationship contract by exceeding the consent given by the patient. Patients can limit the scope of consent given for treatment. Consent limitations expressed by the patient become an integral part of the contract for services. For example, a patient can instruct their treating chiropractor not to adjust their lumbar spine. The subsequent performance of a lumbar adjustment would be a breach of contract and could trigger a malpractice claim. The unauthorized touching of another is actionable in itself as a battery. The commission of a battery can result in both civil and criminal causes of action.

Written Consent

While laws vary from state to state, written consent of a guardian to treat a minor is typically required prior to treatment.

Example:

Written Consent (For a Minor)

Ian Harmsway, D.C.

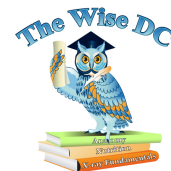
Address

Phone #

Patient Name: Joe Risky

I authorize Dr. Ian Harmsway to perform ancillary diagnostic tests, render chiropractic adjustments and adjunctive physiotherapy treatment to my minor son, Bob Smith. This authorization extends to all other doctors and staff members associated with Dr. Ian Harmsway. I authorize Dr. Ian Harmsway to utilize radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for my minor son, Joe Risky. If my authority to select and authorize treatment is revoked or altered, I will immediately notify Dr. Ian Harmsway.



Date: _____ Signature: _____

Witness: _____ Relationship to Patient: _____



Informed Consent Document

Utilizing a form and having the patient sign and date the form objectively documents that the informed consent process occurred. An initial informed consent form should be utilized before the initiation of treatment and prior to the performance of diagnostic testing. Also, have the patient sign and date a new informed consent document when treatment is altered and when additional diagnostic testing is performed. Tailor the consent form to the individual patient.

Example:

Informed Consent Document

Dr. Anita Turny

Address

Phone #

Name of Patient: Will Sue

A doctor of chiropractic locates, analyzes and treats vertebral subluxation. The primary chiropractic treatment method is the spinal adjustment. I will use spinal adjustments to treat you.

The Chiropractic Adjustment

I will locate vertebral subluxation, position my hands at these locations and administer a force to correct the subluxation. This procedure may result in an audible sound and you may feel movement.

Risks Associated with Spinal Adjustments

Complications may occur during the deliverance of a spinal adjustment. These include muscle strain, ligament sprain, fracture, disc injury, dislocation, paralysis, stroke, stiffness and soreness.

Risk Probabilities

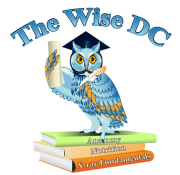
The above referenced complications are rare. One authoritative source opined that there was a one in one million chance of stroke as the result of a cervical adjustment. (Haldeman, Scott, MD, DC).

Alternative Treatment Options:

Self treatment to include over the counter medication.

Medical treatment to include the use of prescription drugs and physical therapy.

Surgery.



Hospitalization.

Risks of Alternative Treatment

Overuse and improper dosage of over the counter medications may produce undesirable side effects.

Overuse and improper dosage of prescribed medications can lead to undesirable side effects and drug dependence.

Risks associated with surgery include adverse reactions to anesthesia; surgical errors and protracted periods of convalescence.

Risks associated with hospitalization include expense, exposure to disease, and physician and staff errors and omissions.

Risks of Not Receiving Chiropractic Treatment:

Risks associated with not receiving chiropractic treatment may include chronic symptomatology, reduced ranges of motion, the onset of arthritis and reduced activities of daily living.

I hereby attest that Dr. Anita Turney has explained the type of chiropractic treatment to be utilized, the nature and risks of spinal adjustments, the risk probabilities, alternative treatment options and their associated risks and the risks of not receiving chiropractic treatment. I understand the risks involved in undergoing treatment and have of my own volition decided to undergo the treatment provided by Dr. Anita Turney. I hereby give my consent to treatment by Dr. Anita Turney.

Date: _____

Signature: _____

Printed Name: _____

Witness Name: _____

Witness Signature: _____

Diagnosis and Patient Referrals

Failure to accurately diagnose and properly refer a non progressing patient is two common causes of malpractice claims against Doctors of Chiropractic.

Patients seek the services of a chiropractor to establish an accurate diagnosis and obtain appropriate treatment. Approximately 90% of the chiropractor's diagnosis comes from the reported history while the remaining percentage is derived from physical examination findings. This underscores the significance of thorough history taking and comprehensive physical examination skills. During the process of differential diagnosis, the D.C. will, based upon examination findings, eliminate a number of



competitive etiologies before formulating an accurate diagnosis. Clinical experience is utilized to differentiate between diagnostic possibilities and diagnostic probabilities. Medically probable is a notion that something is greater than 50% probable.

Patient Management Duties

Upon initial presentation by an individual, and following the history taking and physical examination processes, the doctor must determine if the individual is a candidate for chiropractic treatment. The presence of vital signs is not the sole determining factor of one's candidacy for chiropractic treatment. Reason, logic, experience and intuition will guide you in this determination.

The doctor must arrive at an accurate clinical diagnosis, inform the patient of his findings and treatment plan, receive patient consent and provide quality care directed at resolution of the patient's condition.

The doctor must document daily the patient's response to care noting progression and non-progression.

The doctor must alter treatment for the non-progressing patient.

The doctor must refrain from utilizing treatment methodologies that are not within their state's scope of practice, which demonstrate no physiological benefits or which aggravate the patient's condition.

Referral Liability

Is the chiropractor liable for the negligent actions of a doctor to whom the patient is referred? In a 1973 New Jersey malpractice case, *Tramutola v. Bortone*, the court ruled that a family doctor who referred his patient to a surgeon was not liable for the surgeon's negligent actions. The court opined that only if the referring family doctor had reason to suspect that an injury was likely and failed to disclose that belief, would the referring doctor be liable. This would only be possible if the referring doctor had knowledge of disciplinary actions or malpractice claims against the referral doctor.^{xii}

Historically the courts have concluded that the referring doctor is not liable for the negligent acts of the referral doctor. The exception to this would be two doctors working together in the treatment of a patient. If one of these doctors performs a negligent act, then, both of the doctors would be liable for injuries to the patient.

Reducing Referral Liability

Research the credentials of the referral doctor.

Offer the patient a choice of more than one qualified doctor in a particular specialty.

Refer the patient to the appropriate specialist.

Document the referral. Forward all pertinent patient records and authorizations to the referral doctor.



If the patient is returning to your care after the referral, correlate the information derived from the referral encounter to the patient's condition and treatment plan.

Determine if the patient followed through with referral recommendations.

What Type of Patient should be Referred?

The patient that demonstrates non progression.

The patient whose condition has worsened during the course of chiropractic treatment and is no longer amenable to chiropractic intervention.

Understanding Characteristics of a Non-Progressing Patient

Persistent subjective complaints of pain.

Minimal or no intervals of relief from pain.

Little or no improvement in activity of daily living levels.

Failure to achieve treatment goals.

No change in work status.

Continuous observation by the doctor of these patient characteristics should be a warning signal. The prudent doctor should either alter his treatment approach or refer the patient to another physician specialty. The timing of altering treatment or referral will be different for each individual patient, depending upon their age, sex, diagnosis and the presence of complicating factors.

Risk Management through Documentation

Primary Functions of Health Care Records

Health care records document the immediate care and treatment of the patient. They allow the physician to gauge daily progress.

Records allow other members of your own health care team or other health care providers to have an understanding of the patient's daily subjective complaints, objective findings, procedures performed, and the patient's response to therapy.

Records document your services for reimbursement purposes - they should be clear, concise and legible, written in ink and should not be erased or altered.

Records are critical for legal purposes, including malpractice claims.



Doctor identification on each record is critical especially in the case of multi doctor offices.

Writing in a Medical Record

Medical writing should be accurate, legible, brief, and clear.

Never exaggerate, record falsely, or make up data before examining and treating a patient.

Information should be objective and should never contain criticisms of other physicians or of the patient.

Report information concisely, utilizing short, succinct sentences and standardized abbreviations.
Handwriting must be legible and easily read.

Sign every entry that you make into the medical record using your legal signature. (Especially in a multi-doctor office).

The name of the patient should be legible on each notation and nicknames should never be used.

Notes discuss the patient, therefore, do not refer to yourself.

Documentation Strategies

Protective Strategies

Maintain a daily patient sign in sheet. Never allow your receptionist to sign in for the patient and keep a cover over previous patient signatures to ensure confidentiality.

Have the patient periodically handwrite a list of symptoms and complaints which coincides with the submission of progress reports.

Have the patient periodically hand write, date and sign a progress form which qualifies their status.

Know what is in your forms.

Tailor your patient intake forms to your practice. Read over every form in your office. Forms which contain treatment related historical information at the top of the page and insurance and reimbursement information at the bottom of the page should be separated into two forms. This will reduce inferences that your main concern is reimbursement and not the health and well being of the patient.

Respect the patient's privacy. *For example*, intake forms should not include unnecessary questions about a personal or patient's sexual history. Also, history taking and any other discussions of a personal nature should be done in private. Compliance with HIPPA regulations is strongly stressed.

Every condition or complaint identified by the patient should be addressed.



Avoid the use of treatment frequency schedules as these schedules infer a cookie cutter approach to treatment. The frequency of treatment and the type of treatment provided should be dependent upon the patient's diagnosis, documented response to treatment and clinical progress.

Approximately 90 percent of a doctor's diagnostic impression is derived from information attained during the history taking process. Consequently, the development of accurate and thorough history taking skills is essential. The information derived from the history taking process allows the doctor to arrive at a working diagnosis, develop short term and long term goals and a treatment plan, and render appropriate treatment methodologies.

Never use the terms "Omissions and Errors Included" or "Dictated but Not Read" in any of your documents. This infers a lack of thoroughness and professionalism. Thorough and accurate record keeping is a standard of care and is mandated by many state chiropractic laws.

Document patient noncompliance with prescribed treatment plans. Also, document dates where the patient did not keep a scheduled appointment and record an explanation.

Keep patient records forever. The statute of limitations (the law which establishes a timeframe beyond which a suit cannot be brought) varies from state to state and is subject to a wide range of judicial interpretation. In some states, the time clock doesn't start running until the injury is discovered or, in the case of a child, until they reach adulthood.

Record daily patient encounters utilizing S. O. A. P. notations. These notations should be documented contemporaneous with the patient encounter. Avoid writing all of your patients daily office notes at one time at the end of the day because recollection can be skewed with the passage of time.

Case Scenario--During the course of a trial a chiropractor testifies that he provided services to a patient on January 2, 2004. However, evidence is produced which reveals this patient was actually in another state on vacation on January 2, 2004. What effect would these facts have on the credibility of the chiropractor? While mistakes can occur, billing for services which were not provided can result in insurance fraud investigation and manual claims review of all of that doctor's billing submissions.

Introduction to S. O. A. P. Notes

The Gold Standard for daily office notations is the S. O. A. P. note. S. O. A. P. is an acronym, with each letter representing a section of the patient note. S. stands for subjective complaints; O. stands for objective findings; A. stands for clinical assessment; and P. stands for treatment plan.

The S. O. A. P. note was introduced by Dr. Lawrence Weed as a method of organizing medical records.

The S. O. A. P. note records what the physician does to manage the patient's condition on a daily basis and is a standardized form of communication. Third party payers make decisions about reimbursement based on the quality, legibility, and completeness of daily office notations. The method of writing S. O. A. P. notes helps the physician to organize the thought processes involved in patient care and offers a



structured way of thinking for problem solving. They are also used for quality assurance and improvement purposes and chronicle subjective and objective improvement, patient response to treatment, and the efficacy of care.

S - Writing Subjective Complaints

Document the patient's subjective complaints in the words of the patient. The subjective complaint will include information regarding the patient's area/areas of pain, level of function, response to treatment, emotions, goals of care, lifestyle or home situation, emotions and attitudes.

It is acceptable to use "Pt." the first time, but do not repeat it with every sentence, as it is implied that the information in this section came from the patient.

Quoting the patient verbatim is the most appropriate method of conveying subjective information. Some reasons for using direct quotes from the patient might be to illustrate confusion or loss of memory, denial, attitude toward therapy or the use of abusive language.

The subjective portion of the note includes pertinent information that will assist the physician with setting treatment goals for the patient, planning the patients treatment, and deciding when to discontinue treatment.

O - Writing Objective Findings

The objective part of the note is the section in which the results of tests and measurements performed and the physician's objective observations of the patient are recorded. Objective data are the measurable or observable information used to plan patient treatment. Objective information reported in one note can be compared with measurements taken and recorded in the past to monitor patient progress.

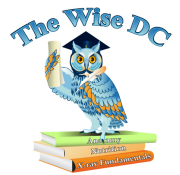
Objective findings which may be found in S. O. A. P. notes may include orthopedic, neurologic, and chiropractic findings. A testing procedure that illicit a positive finding should be noted and re-tested on the next date of treatment.

Information derived from objective testing should be organized under headings, should be written in a clear and concise manner and should list the results of objective measurement procedures performed by the physician.

A - Writing Assessment

The assessment section of the daily office note provides a summary of the patients major problems as written in the Subjective and Objective parts of the note. Assessment includes diagnostic impressions, patient response to treatment, short term goals, long term goals and expected functional outcomes.

Goals: 1) Written to help plan treatment that meets the needs and problems of the patient, 2) Prioritize treatment and measure effectiveness, 3) Communicate to a third party the duration, frequency and types of treatment needed to resolve the patients problem.



Short term goals are written as steps along the way to achieving long term goals.

Long term goals are written to describe how each of the patient's problems will be finally resolved.

Expected functional outcomes list the functional level that the patient is expected to reach by the time he or she is discharged from therapy.

P - Writing Plan

The Plan part of the note is the final step in the planning process for patient care.

Information that must be included in the plan section of a note: 1) Frequency that the patient will be seen. 2) Treatment provided and proposed.

Information that may be included in the plan section of a note: 1) Location of the treatment (in office, at home, in a pool, gym). 2) Plans for further assessment, reassessment, or discharge 3) Equipment needs and equipment ordered. 4) Referral for cross discipline examination/treatment or ancillary diagnostic testing.

S.O.A.P. Note Example:

Date: 1/01/02

Patient's Name: I.M Hurtin

Patient's Signature: _____

Doctor's Signature: _____

S - "I have a pain in my neck which travels down into my right arm and numbness in my right hand and fingers. I feel about the same as I did yesterday."

O - Decreased, painful cervical flexion 35o/50 o; extension 28 o/60o; right rotation 54o/80o; right lateral flexion 37o/45o; (+) positive Cervical Distraction, and Foraminal Compression on the right; all upper extremity reflexes are normal (biceps, C5; brachioradialis C6; triceps C7; finger flexors C8; hand intrinsic C8); (+) positive Tinel's and Phalen's Tests.

A - Cervical nerve root compression; carpal tunnel syndrome right wrist. Patient's response to treatment has been slow, complicated by work duties as a secretary. Short term goal is pain relief.

P - A change in treatment was discussed with the patient and implemented. Patient consent was given (see consent form). Diversified cervical adjustments to C5 PL and C6 PL remain unchanged. The use of heat therapy to the cervical spine was discontinued, replaced by manual cervical traction. Treatment



is to continue at 3x per week for 1 week followed by re-examination. Referral for neurological evaluation was advised. Drs. Johnson and Smith were recommended. The patient wants to consider this option and we will discuss further in one week.

Summary of Do's and Don'ts of Record Keeping

Do.

Maintain records in ink.

Make additions and changes appropriately.

Identify patient name, date and year of service. Document unusual events.

Identify the record keeper.

Record all patient contacts.

Maintain legibility.

Maintain a legend for any codes used.

Maintain records forever.

Fill in all blanks or make a line through blank spaces.

Initial all documents rather than scratching out the entire record.

Customize the forms used.

Document patient non-compliance.

Proof-read correspondence and reports.

Don't:

Erase, skip lines, leave spaces, "squeeze in" notes, use correction fluid, or back date or alter.

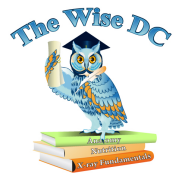
Say anything disparaging about the patient.

Avoid judgmental words.

Ever enter data prematurely.

Avoid ambiguous words.

Criticize other providers.



Use two different pens on the same day's entry.

Alter records.

Use computer generated notes unless individualized.

Other Types of Protective Documentation

Patient Sign - In Sheets

Daily patient sign-in sheets provide a handwritten record of a patient's presentation for care on a particular date. This protects against allegations of insurance fraud. Only the patient should sign the sheet with no substitutions. Some practice management companies tell their students to list 5, 10 or 15 fictitious names on their daily sign-in sheet before their first patient of the day arrives to produce an illusion of a successful office. This practice should be avoided. If uncovered, this dishonest act could destroy the credibility of the doctor in his community and could be a valuable tool for a plaintiff's attorney in a malpractice suit.

Patient Symptoms List

Create a symptoms list form and have the patient handwrite their symptoms and complaints. These lists can be used periodically, such as at the time of a re-examination, as their daily use would be too time consuming.

Example Symptoms List

Today I have neck, back and right leg pain with numbness in my right foot.

Date: _____

Patient: I.M. Hurting

Patient Signature: _____

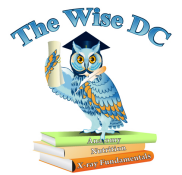
Patient Progress Report

A patient progress report, written in their own words or checked off in a list format, done periodically, can offer a record of the patient's perception of clinical progress. For ultimate malpractice protection, the form must be completed, dated and signed by the patient only.

Example:

Patient Progress Report

Since my last exam:



1. Improved _____
2. Unchanged _____
3. Worse _____
4. Resolved _____
5. Other _____

Date: _____ Patient Name: _____ Patient Signature: _____

Document Patient Non Compliance

A patient's failure to follow through with a doctor's recommendations should be documented. Every doctor will have a different tolerance level for non compliant patients. Examples of patient non compliance include:

Failure of the patient to show for scheduled appointments.

Failure of the patient to perform prescribed at home therapy such as the use of ice/heat or exercise.

Failure of the patient to refrain from working, lifting, bending, sports activities, school, driving and housework.

Failure of the patient to heed recommendations for life style modifications.

Non-Compliance Notifications

Non-compliant patients should be discharged from care, notified of their non-compliance specifying discussed and agreed to treatment plans, dates and types of non-compliance and referred to another provider of care when appropriate to prevent a claim of abandonment.

How Long Should You Keep Records?

As a general rule of thumb, maintain patient records forever. Also, be knowledgeable of the statute of limitations for your particular state. Most states have statutes of limitation of 3 - 7 years. This means that a malpractice claim must be made within 3-7 years after the date of the negligent act. There is an exception which applies to a negligent act against a child. A person that claims to have been a victim of a negligent act while they were a child must bring suit within one year after their 18th birthday.



Discharge Notations

Discharge notes summarize the treatment the patient received, the total number treatments received, patient response to treatment, any patient education performed, instructions or equipment given or sold to the patient, and recommendations for future treatment or follow up care.

Documentation Forms

Documentation forms decrease the amount of writing by the physician, increase the efficiency of documenting patient care, increase the consistency of documentation, provide consistent data gathering and present organized, clinical information that is more easily read by all of the parties who use the information.

Computerized Documentation

Advantages of Computerization Documentation

Computers can have all of the orthopedic, neurologic and chiropractic tests and measurements readily available to the physician.

Limitless space to place the information gathered.

Documentation tailored to the specific needs of the physician.

Information is presented in a clear, concise and legible manner.

Quick data entry by simply touching a stylus to the computer screen.

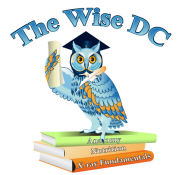
Disadvantages of computerized documentation

Repetitive, unaltered reporting of daily subjective complaints, objective findings, assessment and plan will raise a red flag. Static clinical information implies unresponsiveness to the treatment rendered.

Limitations of the computer program may limit reporting capabilities.

Consent to X-ray a Pre-menopausal Patient

The prudent doctor will advise all pre-menopausal patients of the risks of radiographic examination of the pelvic region during pregnancy. Inform the patient that embryo damage following radiation exposure during the first trimester of pregnancy has been chronicled. Have the patient document the date of onset of their last menses, and sign consent to x-ray. Create a consent form which states the risk of x-ray during pregnancy, have the patient respond to questions regarding their pregnancy status, use of contraceptives, regularity of menstrual periods, and gynecological history, such as a history of



hysterectomy and date of their last menstrual period. Have the patient sign and date the form and include a witness signature.

Telephone Call Form

Create a telephone log form and make entries for all calls which have clinical significance. This form should always be used when a patient calls the doctor to discuss a clinical aspect of their case. The form is not needed when a patient calls to schedule an appointment. The telephone call form is dated and lists all calls from all patients on a particular day. Do not use separate call logs for each patient. Documenting calls from all patients in one daily telephone call form offers an accurate and believable call chronology and reduces any perception that a documented call was fabricated.

Patient Survey

Utilize patient surveys to determine your patient's level of satisfaction with your care, and with your staff. If the survey chronicles a number of consistent complaints, take the appropriate actions to remedy the problem.

Some practice management groups have advised their students to utilize Release of all Claims forms to rectify patient complaints about the effectiveness of care and demands for monetary refunds. A release is a binding contract, in which a patient agrees to sell his right to make a claim against a doctor in exchange for an agreed to amount of money. This type of an agreement can easily be construed as an admission of guilt by the doctor. Many malpractice insurance carriers have specific policy language forbidding the insured doctor from attempting to settle his own claims. Consequently, it is advisable to not create or sign Release of All Claims forms.

Child Abuse and Neglect Reports

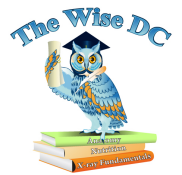
The child protection laws of most states mandate a doctor report all suspected cases of child abuse and neglect. Failure to do so may result in a malpractice suit, (brought by the victim or their guardian arguing that additional damages may have been mitigated if a report was filed); fine; or imprisonment.

Patient Authorization

Before releasing a patients records to a third party, have the patient sign an authorization consenting to the release of their medical records. Never release original records and make sure that the authorizations are current (not more than approximately 60-90 days old).

(Example) Patient Authorization to Release Information and Medical Records

I authorize Dr. Purdy Careful and his employees to provide to the person(s) listed below, all medical information, and records requested, pertaining to any examination, treatment, or condition that I have had in the past, presently have, or may have in the future.



Party Requesting Records

Name: Dr. John Smith

Address: _____

Patient Name: _____

Patient's Signature: _____

Patient Address: _____

Date: _____

Treatment Withdrawal Letter

A treatment withdrawal letter, where a doctor unilaterally withdraws from providing services to a patient, is a letter of last resort. Prior to sending this letter, the doctor should send the patient a non-compliance notification specifying the patient's non-compliant actions (ex. Failure to perform prescribed at-home therapy, failure to lose weight, failure to follow work restrictions, and failure to make scheduled appointments etc.). If the patient's non-compliance can not be remedied, then it is advisable for the doctor to withdraw from treating the patient. In the withdrawal letter the doctor must; offer the patient sufficient notice of withdrawal allowing the patient to find another doctor; send the letter certified, return receipt requested; maintain record of the letter in the patient's file. It is not imperative that the doctor specify the reasons for his withdrawal of treatment as the reasons were clearly specified in the prior non-compliance notification.

Peer/Record Review Preparation

The following documents must be submitted for third party review;

Initial Narrative Report

Initial Examination Findings

Roentgenological Report

Periodic Re-Examination Findings

Daily Office Notations

Billing Statements



Cross Discipline Examination Findings

Ancillary Diagnostic Test Results

Letters of Medical Necessity

Discharge Summary

Follow Up / Final Narrative Reports.

Recording a History of Care

Each document must have the date of the procedure

Date of injury / mechanism of injury / emergency room treatment, hospitalization records.

Treatment history prior to chiropractic treatment

Synopsis of chiropractic treatment to include duration / frequency of care, total number of visits, type of treatment

Synopsis of treatment rendered by other providers of care, and ancillary diagnostic test results

Current frequency of care, diagnosis, type of treatment, concurrent treatment, recent diagnostic tests, provider's rationale for treatment and recommendations for future care

Recording History and Examination

Initial Case History

Date and mechanism of the onset

Nature and location of the injuries sustained

Presenting subjective complaints (note the intensity, character, duration and frequency of the complaint)

Past medical history

Prior treatment for the presenting complaint

Social/work/family history

Physical, Orthopedic, Neurologic, Chiropractic Examination.

Diagnostic x-rays and or other studies indicated by examination.

Formulation of a Diagnostic Impression / Treatment Goals / Treatment Plan.



Chiropractic treatment - manipulation, passive physiotherapy and active rehabilitation.

Periodic re-examination performed approximately every 8-10 visits, every 30 days or as clinically necessary in the judgment of the attending physician.

Narrative Report Writing

All narrative reports should contain the following;

The Beginning - which paints a picture for the reader explaining the onset of an injury or illness;

The Middle - which contains the patient's current condition and the physical examination

The End - This contains the bottom line of the report specifying the author's conclusions.

Report Format

Introduction (Beginning)

This portion of the report identifies the author, and date of the report, who requested the report, who the report is about, why the report was done, the date of accident and the type of examination performed.

Dear Mr. Shady:

Brent Bumper is a 27 year old male whom I examined at your request on January 2, 2004 for evaluation of injuries sustained in an automobile accident on December 20, 2003. I performed chiropractic evaluation of his head, spine, torso, and upper and lower extremities. The results of my evaluation are contained in the body of this report.

History of the Injury/Cause

This portion of the report should describe the date of injury, the mechanism of injury and the nature and location of the injuries sustained. Identify what transpired after the accident including any type of emergency room treatment or hospitalization. Avoid embellishing the history with graphic terms that may infer bias. For example, "The patient experienced a bone-jarring impact that severely injured his spine".



Effect on Work or ADL's

Identify the patient's ability or inability to perform his normal and customary job requirements.

Past History

This section is used to reveal injuries, illnesses or accidents which may have a bearing on this particular accident. Identify prior accidents, treating providers, type of care rendered, the length of treatment, permanent restrictions or impairments and how long it has been since the patient was treated for that particular injury.

Surgical History

Record all surgical procedures.

Middle of the Report

Current Condition

This portion of the report should describe the patient's condition from head to toe. Each area of the body should be reported on, whether the patient complains of problems or not.

Physical Examination

Reproduce your examination form findings in this portion of the narrative report to include vital signs, chiropractic analysis, range of motion, orthopedic and neurologic findings.

Roentgenological Analysis

Identify the date of examination, number and position of the views taken, assessment of bone alignment and quality, assessment of soft tissue structures, culminating with your clinical impression and diagnosis.

Diagnosis

This portion of the report states the condition detected. It is important to remember that the diagnosis should be a condition, such as subluxation and not a symptom, such as cervicalgia. Avoid embellishing the diagnosis and using vague terms. For example; using the term multiple spinopelvic disrelationships, instead of pelvic subluxation. The diagnosis must be compatible with other portions of the report, understandable to others and summarize the patient's condition.

End of the Report

Comments and Conclusions

This portion of the report is often read first by third parties. Consequently, this section is often started with a summary of the facts of the case followed by your response to questions posed by the referral



source regarding reasonableness and necessity of care, causal relation, apportionment permanent impairment and maximum chiropractic improvement.

Prognosis

In this section the author is asked to predict the future for the patient. Rely on your past experience in treating similar cases and support your opinions with available, current literature.

Future Medical Care

Opine whether future care will be curative or palliative in nature. Curative care provides improvement in the condition and infers the patient has yet to reach maximum chiropractic improvement. Palliative care provides relief for the patient but does not cure the effects of the injury.

Documenting Maximum Chiropractic Improvement

Clinical Criteria for Ending Care acknowledgment - (Medical--Legal Issues In Chiropractic, Volume 1, 1990, Stephen M. Forman)

When the upper and lower limits of subjective pain have been established after a trial period of treatment. *For example*, if after two months of regular chiropractic treatment, the patient reports feeling great for 24 hours following the adjustment only to return to the same intensity as before the adjustment. This signifies the patient will only attain palliative relief from the treatment and maximum improvement has been achieved.

When the patient fails to progress clinically between treatments.

When the patients symptoms worsen during the treatment program.^{xiii}

Documenting the Reasonableness and Necessity of Supportive Care

The following criteria must be documented to substantiate the reasonableness and necessity of supportive care;

The patient must be deemed to have reached a point of maximum chiropractic improvement.

There must be documented, objective evidence of a permanent injury.

There must be documented, clinical trials of withdrawal from treatment which resulted in exacerbation.

Supportive treatment should never be prescheduled and should be provided solely in response to a documented exacerbation.

Supportive treatment should provide relief of symptoms/increased activities of daily living.



Record attempts at alternate care and the patient's response

Exhaust other forms of possible treatment

Generally, this care will average approximately 2 visits per month.

Documenting the Reasonableness and Necessity of Ancillary Diagnostic Testing

The purpose of ancillary diagnostic testing (i.e. advanced imagery, electrodiagnostics, labs, etc.) is to aid in the development of a differential diagnosis. In general, to justify the referral for, or the provision of an ancillary diagnostic testing procedure, there must first have been a trial course of treatment which did not result in resolution of the patient's condition. Secondly, the attending chiropractor must document positive objective findings consistent with the type of testing procedure ordered or performed. Thirdly, the timing of the testing procedure is essential. For example, an E. M. G. test would not be clinically indicated on the date of injury. Lastly, the attending chiropractor must correlate the information derived from the testing procedure to the patient's condition and treatment plan.

Applying CPT Coding

The use of Physicians' Current Procedural Terminology is the most accurate method of documenting the level of work a physician performs and reporting the array of physician level services delivered.

Goal of Treatment - Select and administer those services which will most likely yield the greatest therapeutic benefit in the shortest period of time.

Always inform the patient and insurer in a timely manner of treatment goals and plans after giving consideration to normal healing times, phase of care and complicating factors.

Benefits of CPT Coding

The work values of CPT codes are developed through an established measurement process which is based on the time, technical skill and mental effort required to perform each service.

Drawback of CPT Coding

There are inherent limitations in the CPT process that may not adhere to a provider's philosophical perspective. It creates a rigid format for recording services. The CPT process may also be formulated in error, such as placing a code in the wrong family of codes. Corrections of this mistake may take months or years to correct and could impact reimbursement negatively.

Components of Physicians' Total Work Time for Manipulation Procedures



The “Work per unit of time” or work value of CPT codes in general are based not only on the amount of time spent with a patient, but also the amount of work (including physician skill and judgment that is required in the visit.) This work per unit of time is divided into three sections:

Pre-service (before patient arrives)

Documentation and chart review

Imaging review

Test interpretation and care planning

Intra-service (face-to-face time with patient)

Pre-manipulation (e.g., palpation, ROM, etc.)

Manipulation

Post manipulation (e.g., assessment, procedures, etc.)

Post-service period (after patient leaves)

Chart documentation

Consultation

Reporting

Generally, the higher the work unit value, the larger the payment.

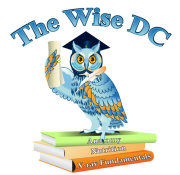
CMT Code Descriptions for Chiropractic Services

Four Chiropractic Manipulative Treatment (CMT) codes (CPT 98940 - 98943) were added to the Medicine Section of CPT in 1997. The three spinal CMT codes replace the A2000 code, in the Medicare Fee Schedule.

Chiropractic manipulative treatment is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

Chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

Additional evaluation and management services may be reported separately using the modifier -25, if and only if the patient’s condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.



The Five Spinal Regions for CMT

Cervical Region

Thoracic Region - including costovertebral and costotransverse joints

Lumbar Region

Sacral Region

Pelvic Region

The five extraspinal regions referred to are:

Head - temporomandibular joint, excluding atlanto-occipital region

Lower extremities

Upper extremities

Rib Cage - excluding costotransverse & costovertebral joints

Abdomen

Breakdown of Codes

98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions.

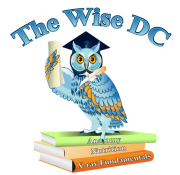
98941 Spinal, three to four regions.

98942 Spinal, five regions.

98943 Extraspinal, one or more regions.^{xiv}

Spinal / Extraspinal Manipulative Treatment

Spinal - Regardless of how many manipulations are performed in any given spinal region (cervical, thoracic, etc.) it counts as one region under the CMT codes. For example, chiropractic manipulation applied to C2, C3 and C5, during one patient visit would represent treatment to one region (cervical) and, if these were the only manipulations performed during the visit, the appropriate code to use would be 98940.



Extraspinal - It is appropriate to use code 98943 to describe Chiropractic Manipulative Treatment to one or more extra-spinal regions, regardless of how many individual extra spinal manipulations are actually performed. The extra-spinal CMT code 98943 can be used either by itself or in conjunction with a spinal CMT code. In those cases when 98943 is used in conjunction with a spinal CMT code, it is necessary to add a -51 modifier (98943-51).

Clinical Scenarios

CMT 98940 - Chiropractic manipulative treatment (CMT); spinal, one to two regions.

Example: 32-year-old female established patient presents with mid and low back pain; brief evaluation including review of systems and a focused examination reveals that manipulation is indicated in 2 regions, the thoracic region (T6) and lumbar region (L4); treatment - diversified manipulation (T6, and L4); chart entry and documentation.

CMT 98941 - Spinal, three to four regions.

CMT 98942 - Spinal, five regions.

CMT 98943 - Extraspinal, one or more regions.

Example: 56-year-old female; established patient; right and left hand and wrist pain; brief evaluation including review of systems and a focused examination reveals that extraspinal manipulation is indicated in two regions; the right and left upper extremities (Right / Left hand and wrist); treatment - manipulation of Right / Left hand and wrist; post service work to include chart entry and documentation.

Note for use of extraspinal code: The extraspinal code can be used by itself or in conjunction with a spinal CMT code. When used on the same day as another CMT code, the extraspinal code should have a “-51” modifier attached. The -51 modifier reduces the RVU of 98943 by 50 percent under the Medicare payment system.

Important Points

You could use E / M codes and 97140 (Manual Therapy Techniques) codes together.

E / M code can be used with a CMT code; however the E / M code would necessitate a -25 modifier.

Example: E / M 99202-25

Precursors to utilizing CMT Codes

Patient Complaint

Objective finding of subluxation



Diagnosis of subluxation

Medicare P.A.R.T. Guidelines

January 1, 2000 marked the end of the mandated X-ray era for Chiropractic's Medicare patients. Medicare guidelines were revised to give the option of using x-rays or using P.A.R.T. (Pain, Asymmetry/Misalignment, Range of Motion Abnormality, and Tissue/ Tone).

Medicare carriers Manual Utilization Guidelines (Section 2251.2)

Subluxation-Subluxation is defined as a motion segment, in which alignment, movement integrity and/or physiological function of the spine are altered although contact between joint surfaces remains intact.

Documentation of Subluxation-A subluxation may be demonstrated by an x-ray or by physical examination, as described below.

Demonstrated by X-Ray: An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken not more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

Demonstrated by Physical Examination-Evaluation of musculoskeletal nervous system to identify:

Pain/tenderness evaluated in terms of location, quality, and intensity

Asymmetry/misalignment identified on a sectional or segmental level

Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and

Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under "physical examination" are required, one of which must be asymmetry/misalignment or range of motion abnormality.

Documenting History

The history recorded in the patient record should include the following:

Symptoms causing patient to seek treatment;



Family history if relevant;

Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);

Mechanism of trauma;

Quality and character of symptoms/problem;

Onset, duration, intensity, frequency, location and radiation of symptoms;

Aggravating or relieving factors; and

Prior interventions, treatments, medications, secondary complaints.

Documentation Requirements- Initial Visit

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

a.) History as stated above.

b.) Description of present illness including:

Mechanism of trauma;

Quality and character of symptoms/problem;

Onset, duration, intensity, frequency, location and radiation of symptoms;

Aggravating or relieving factors; and

Prior interventions, treatments, medications, secondary complaints;

Symptoms causing the patient to seek treatment.

Symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine, muscle, bone, rib, and joint and be reported as pain, inflammation, or as signs such as swelling, spasticity.

Evaluation of the musculoskeletal/nervous system through physical examination.

Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.



Treatment plan: The treatment plan should include the following:

Recommended level of care (duration and frequency of visits);

Specific treatment goals; and

Objective measures to evaluate treatment effectiveness.

Date of the initial treatment.

Documentation Requirements – Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination

a.) History

Review of chief complaint.

Changes since last visit.

System review if relevant.

b.) Physical exam

Exam of area of spine involved in diagnosis.

Assessment of change in patient condition since last visit.

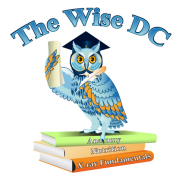
Evaluation of treatment effectiveness.

c.) Documentation of treatment given on day of visit.^{xv}

E/M Codes Unbundling (ChiroCode Desk Book 2004)

There are two types of unbundling: the first is unintentional which results from a misunderstanding of coding, and second is intentional, used by providers to manipulate coding in order to maximize payment. Unbundling is essentially the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code. Correct coding means reporting a group of procedures with the appropriate single comprehensive code. Examples of unbundling are:

Fragmenting one service into component parts and coding each component part as if it were a separate service. An example would be coding for a routine 99202 (E/M services) with a 98941 (Manipulation/Adjustment), unless the E/M component is for significant separately identifiable service as in new accident work up. (The later case would be expressed with a '-25' modifier.)



Mutually Exclusive Procedures are those which cannot be performed reasonably during the same operative or patient session. Codes should not be reported together when the same or similar repair or treatment is by two different methods, i.e. Chiropractic Manipulation Treatment (CMT) and Osteopathic Manipulation Treatment (OMT).

Component procedures are those that are in a family of codes. In a family of codes, there are more than 2 components that should not be reported separately because they are included in a more comprehensive code as member of the code family. The component codes are members of the comprehensive code family and represent parts of the procedure that should not be listed separately when the complete procedure is done. i.e. CMT-98940 is a component of 98941 and 98942 and should not be listed separately.^{xvi}

CPT Position on the Use of CMT Codes

"Chiropractic manipulation treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional Evaluation and Management services may be reported separately using a modifier.

When to use E/M codes? When Significant Separately Identifiable Services exist! It could be with either new or established patients or in initial or subsequent care settings.

The most common occasions for such E/M service encounters in addition to CMT would be:

Initial evaluation

Periodic re-evaluation

Exacerbation

Re-injury

Release or discharge from active care

Examples:

Example of CMT care with significant new patient E/M services:

There is an initial workup and care which required a significant separately identifiable History, Examination and Clinical decision making, with nominal Counseling time.

98941 CMT 3-4 spinal regions

99203-25 Significant E/M service for new patient



Example of subsequent CMT care with major E/M Counseling services:

There is a nominal history, examination (which is a routine part of the CMT service), but there is also a significant separately identifiable doctor-patient face-to-face counseling time and/or coordination of care factor. (Counseling has 7 components: report of findings, prognosis, risks and benefits of treatment options, instructions for treatment and/or follow-up, importance of compliance, risk factor reduction, or patient/family education).

98941 CMT 3-4 spinal regions

99213-25 Significant E/M service for established patient

When you provide valid significant and separately identifiable E/M services which are not a part of routine CMT care, you are entitled to file for reimbursement (except for Medicare and others who deviate from CPT guidelines).

E/M Background

One of the least understood elements of proper chiropractic coding is Evaluation and Management (E/M) coding. It was introduced in 1992 following a 10 year study by the Health Care Financing Administration (HCFA) and the American Medical Association (AMA). The purpose of the new codes was to establish parity between health care providers in the reimbursement process.

E/M Rules

E/M coding has specific rules and requirements for usage. If you provide valid E/M services, you are entitled to bill for reimbursement (except for Medicare, which only recognizes the three CMT codes.) Billing an E/M code to cover manipulation visits is not appropriate. However, an E/M code can and should be used when it is a separately identifiable procedure.^{xvii}

Evaluation and Management (E/M) Services

E / M codes are divided into broad categories (i.e. office visits, hospital visits, and consultations). There are two subcategories for office visits (new patient and established patient. E / M codes are determined by the following:

The place of service, e.g. office, hospital, etc.

Type of service, e.g. initial evaluation, follow up visit

Content of the service - type of history and examination, e.g. comprehensive history and examination.

Degree of medical decision making, e.g. straightforward, low complexity, moderate complexity, high complexity.



Nature of the presenting problems, e.g. self limited or minor → moderate to high severity.

The time typically required to provide the service is specified e.g. 99201 is 10 minutes; 99205 is 60 minutes.

Selecting the Appropriate level of E/M Service – 5 Key Components

1. History
2. Examination
3. Medical decision making
4. Nature of presenting problem
5. Time

The first three of these components (i.e., history, examination, and medical decision making) should be considered the **key** components in selecting the level of E/M services.

Determine the Extent of History Obtained

The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem focused: chief complaint; brief history of present illness or problem.

Expanded problem focused: chief complaint; brief history of present illness; problem pertinent system review.

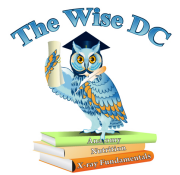
Detailed: chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; pertinent past, family, and/or social history directly related to the patient's problems.

Comprehensive: chief complaint: extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history.^{xviii}

Determine the Extent of Examination Performed

The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem focused: a limited examination of the affected body area or organ system.



Expanded problem focused: a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed: an extended examination of the affected body area(s) and other symptomatic or related organ system(s).

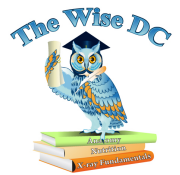
Comprehensive: a general multi-system examination or a complete examination of a single organ system. Note: The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified.

Musculoskeletal Examination – Single Organ System

<u>System/Body Area</u>	<u>Elements of Examination</u>
<i>Constitution</i>	Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight, (May be measured and recorded by ancillary staff) General appearance of patient (eg, development, nutrition, body habitus, deformities,
<i>Cardiovascular</i>	Examination of peripheral vascular system by observation (pulses, temperature, edema, tenderness)
<i>Lymphatic</i>	Palpation of lymph nodes in neck, axillae, groin and/or other location
<i>Musculoskeletal</i>	Examination of gait and station Examination of joint(s), bone(s) and muscle(s) / tendon(s) of four of the six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity;



	4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes: Inspection, percussion and/or; Assessment of range of motion with notation of any pain (straight leg raising), crepitation or contracture Assessment of stability with notation of any dislocation (luxation), subluxation or laxity Assessment of muscle strength and tone with notation of any atrophy or abnormal movements
<i>Skin</i>	Inspection and/or palpation of skin and subcutaneous tissue (scars, rashes, lesions, ulcers) in four of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity.



Neurological/Psychiatric

Test coordination (e.g. finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

Examination of deep tendon reflexes and/or nerve stretch test noting pathological reflexes (e.g., Babinski)

Examination of sensation (e.g., by touch pin, vibration, proprioception)

Brief assessment of mental status, including:

Orientation of time, place, and person

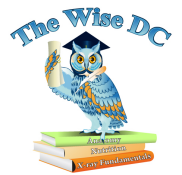
Mood and affect (e.g., depression, anxiety, agitation)

Single Organ System Examination - The performance and documentation of the following number of examination elements determine a specific level of exam.

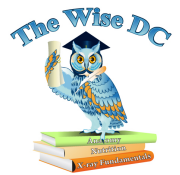
<u>Level of Exam</u>	
One to five elements identified by a bullet	Focused
At least six elements identified by a bullet	Expanded
At least twelve elements identified by a bullet	Detailed
All elements identified by a bullet	Comprehensive

Neurological Examination - Single Organ System

<u>System/Body</u>	<u>Area Elements of Examination</u>
<i>Constitution</i>	Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature,



	6) height, 7) weight. General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
<i>Cardiovascular</i>	Examination of carotid arteries (e.g., pulse amplitude, bruits) Auscultation of heart with notation of abnormal sounds and murmurs
<i>Neurological</i>	Evaluation of higher integrative functions, including: Orientation of time, place and person Recent and remote memory Attention span and concentration Language (e.g., naming objects, repeating phrases, spontaneous speech) Fund of knowledge (e.g., awareness of current events, past history vocabulary)
<i>Musculoskeletal</i>	Examination of gait and station Assessment of motor function, including: Muscle strength in upper and lower extremities Muscle tone in upper and lower extremities (e.g., flaccid, spastic) with notation of any atrophy or abnormal movements (e.g., fasciculation)



Single Organ System Examination -The performance and documentation of the following number of examination elements determines a specific level of exam.

<u>Level of Exam</u>	
One to five elements identified by a bullet	Focused
At least six elements identified by a bullet	Expanded
At least twelve elements identified by a bullet	Detailed
All elements identified by a bullet	Comprehensive

Determine the Complexity of Medical (Clinical) Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

The number of possible diagnoses and/or the number of management options that must be considered.

The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.

The risk of significant complications, morbidity and/or mortality associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

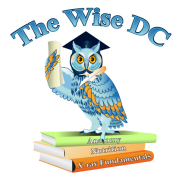
Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements must be met or exceeded.

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E / M codes recognize five types of presenting problems:

Minimal - A problem that may not require the presence of the physician, but service is provided under the physician's supervision. *Example:* headache - physician Rx medication.

Self-limited or minor -A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management compliance. *Example:* mild strain / sprain injury.



Low severity - A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment. Full recovery without functional impairment is expected.

Example: moderate strain / sprain injury.

Moderate severity - A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis or increased probability of prolonged functional impairment. *Example:* disc herniation.

High severity - A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment. – *Example:* aneurysm.

Determining Time

Face-to-face time

That time that the physician spends face-to-face with the patient and / or family. Obtaining a history, performing an examination, counseling the patient, and treatment.

Non face-to-face time

(Pre- and post-encounter time) is not included in the time component described in the E/M codes

E/M Service Codes – New Patient

99201- Office or other out patient visit for the evaluation and management of a new patient, which requires these three key components:

A problem focused history

A problem focused examination

Straightforward medical decision making

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and / or family.

Example: Initial office visit for new patient with a jammed finger.

99202- Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components.

An expanded problem focused history

And expanded problem focused examination

Straightforward medical decision making.



Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and / or family.

Example: Initial office visit with 26-year-old female who awoke with neck stiffness, pain and immobility, but no radiation. One day duration. History of washing walls at home yesterday and slept with window open last evening. No prior history.

99203 - Office or other visit for the evaluation and management of a new patient, which requires these three components:

A detailed focused history

A detailed examination

Medical decision making of low capacity

Usually, the presenting problems(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and / or family.

Example: Initial office visit for evaluation of 13 year old female with progressive scoliosis.

99204- Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

A comprehensive history

A comprehensive examination

Medical decision making of moderate complexity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and / or family

Example: Initial office visit for 26-year-old female injured in auto accident one week prior. She complains of neck and low back pain with right hip pain, left arm pain to the elbow and headaches. History of x-ray exam in hospital emergency room with a prescription for medication that provided no relief of pain.

99205- Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

A comprehensive history

A comprehensive examination

Medical decision making of high complexity



Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and / or family.

Example: Initial office visit for 72-year-old female with disabling mid-thoracic pain, osteoporosis and evidence of healed compression fractures. She slipped on rug at home and fell onto her buttocks with sharp mid back pain and muscle spasm following. Most, if not all, movement extremely difficult.

Established Patient Codes

99211 - Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

Usually the presenting problem(s) are minimal.

Typically, 5 minutes are spent performing or supervising these services.

Example: Office visit for blood pressure check.

99212 - Office or other outpatient visit for the evaluation and management of an established patient which requires at least two of these three key components:

A problem focused history

A problem focused examination

A straightforward medical decision making

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and / or family.

Example: Office visit with 65-year-old female, established patient returns for 3 week follow-up for resolving moderate to severe ankle sprain. No manipulation performed.

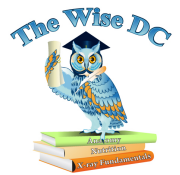
99213 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components.

An expanded problem focused history

An expanded problem focused examination

Medical decision making of low complexity

Usually, the presenting problems(s) are of low to moderate severity. Physicians spend 15 minutes face-to-face with the patient and / or family.



Example: A 42-year-old male, established patient, presents with complaint of pain in the neck, right arm and lumbar regions. He relates new symptoms of numbness and tingling in the right arm and legs since the last visit. Re-evaluation includes expanded problem focused history, expanded problem focused exam (musculoskeletal and neurological examination to the cervical, lumbar and upper and lower extremities), medical decision-making of low complexity.

99214 -Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components.

A detailed history

A detailed examination

Medical decision making of moderate complexity

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

Example: Office visit for examination of new condition of low back pain with radiation to right thigh and mild lumbar antalgia. An established patient seen in past for low back pain only.

99215 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components.

A comprehensive history

A comprehensive examination

Medical decision making of high complexity

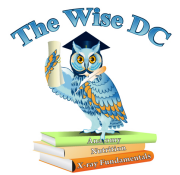
Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and / or family.

Example: Examination of established 32-year-old female patient for new injuries suffered in auto accident involving acceleration / deceleration trauma; overlying history of neck and back complaints.^{xix}

Use of E/M Codes with CMT Codes

E / M codes can be used on the same day of service as a CMT code when clinically warranted. The use of an E/M code in conjunction with the CMT codes requires a -25 modifier.

Example: - A 63-year-old female presents for initial visit with complaints of neck stiffness. No injury, or significant past medical history. Expanded problem focused history and examination with straightforward medical decision making were performed. Diagnosis: Cervicalgia. Cervical (C3, C6) spinal manipulation was administered.



CMT Code: **98940** (One spinal region - cervical)

E/M Code: **99202-25** (Expanded problem-focused history and expanded problem focused examination with straightforward medical decision making meet the audit requirements for 99202)

Expanded and CPT Code Modifiers

Modifiers may be used to indicate:

A service or procedure has both a professional and technical component.

A service or procedure was performed by more than one physician and / or in more than one location.

A service or procedure has been increased or reduced

Only part of a service was performed

An adjunctive service was performed

A bilateral procedure was performed

A service or procedure was provided more than once

Unusual events occurred

Modifiers available in E/M

-21 Prolonged Evaluation and Management Services

-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure:

-51 Multiple Procedures

-52 Reduced Services

ⁱ Webster's New Collegiate Dictionary, C&C Merriam Company, Springfield, Mass., 1976, page 697.

ⁱⁱ Webster's New Collegiate Dictionary, C&C Merriam Company, Springfield, Mass., 1976, page 411.

ⁱⁱⁱ Webster's New Collegiate Dictionary, C&C Merriam Company, Springfield, Mass., 1976, page 769.

^{iv} From Forman, S. and Stahl, M.: Medical Legal Issues in Chiropractic, Volume 1, Number 3, pg. 122, Williams and Wilkins, 1990.

^v From Vernon, H (ed): Upper Cervical Syndrome: Chiropractic Diagnosis and Treatment; Baltimore, Williams and Wilkins, 1988: 199.

^{vi} National Chiropractic Mutual Insurance Company, Back Talk, Spring 1990.



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- vii California Civil Code Section 3333.2 (C) (2).
- viii Webster's New Collegiate Dictionary, G & C Merriam Co., Springfield, Mass, 1976, page 241.
- ix Mercy Conference Guidelines, Recommendation 5.51; pg 90, 1993.
- x Mason v. Forgie, Ct. of Q.B. of New Brunswick's Judicial District of St. John, 1984
- xi Mason v. Forgie, Ct. of Q.B. of New Brunswick's Judicial District of St. John, 1984
- xii Tramutola v. Bortone, 304 A.2d 197, (N.J. 1973)..
- xiii From Forman, S and Stahl, M; Medical-Legal Issues in Chiropractic, Volume 1, 1990.
- xiv Procedure Terminology Manual, PA. Blue Shield, 2000.
- xv Medicare Carriers Manual, December 1999, Section 2251.5.
- xvi Chiropractic Code Desk Book, 2004.
- xvii Chiropractic Code Desk Book, 2004
- xviii Chiropractic Code Desk Book, 2004.
- xix Procedures Terminology Manual, PA Blue Shield, 2000.